DOCUMENTATION TIPS TO AVOID DEFICIENCIES
Bureau or Home Care and Rehabilitative Standards
(Revised 11/2011)

#1) G 337 - DRUG REGIMEN REVIEW (484.55(c))

"The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and non-compliance with drug therapy." Tips to avoid this deficiency include:

- Identify and develop a process for determining potential drug interactions - computer program, internet site, or drug reference guide
- Maintain documentation in the clinical record of significant drug interactions including notification of the physician and physician response
- Identify potential duplicative drug therapy - multiple medications for the same disease process often prescribed by multiple physicians
- High Risk Drug education related to M2010 –
  - Develop policies and procedures related to high risk drug education
  - Develop an agency specific list of high risk drugs
  - Identify and document the high risk drugs taken by the patient
  - Document education provided and the patient's level of understanding
- Drug regimen review for therapy-only cases –
  - Drug review completed by the registered nurse within 5 days of the start of care
  - RN must complete drug review as part of the comprehensive assessment at other required time points
  - RN must provide high risk drug education to the patient within 5 days of the start of care; as part of the resumption of care comprehensive assessment or whenever these drugs are prescribed
- Drugs listed on the medication profile include strength, dosage, frequency, route of administration and reason for prn use
- Assure drugs are spelled correctly
- Include over the counter drugs on the medication profile and in the medication review
- Update the medication profile with new, changed or discontinued drugs
- Document a medication review for all required time points including discharge

#2) DIABETIC ASSESSMENTS AND MANAGEMENT

If the primary or secondary diagnosis is diabetes and diabetic interventions and goals are included on the plan of care, there are specific things that should be documented in the clinical record.

- When completing the comprehensive assessment – assess and document the patient or caregiver's baseline knowledge of the disease process of diabetes – this is your basis for further teaching
  - Document if the patient has a glucometer and if he/she knows how to use it. If the patient is unable to use the glucometer is there a caregiver who checks the blood sugars
  - Assess and document how often the patient checks the blood sugar and what the blood sugars have been running
  - Is the patient or caregiver able to fill syringes and administer insulin
  - Is the patient compliant with oral diabetic medications and insulin administration
  - What is the patient's level of knowledge regarding diet restrictions

  - Document high risk drug teaching related to diabetic medications and what problems to report to the physician
- Assess and document on the plan of care when the physician wants the patient to check blood sugars and the parameters for reporting abnormal readings (either physician ordered or agency established)
- Sliding scale insulin - the physician order must include the specific dosages to be administered for specific blood sugar readings and the times when testing and administration should occur
- During subsequent visits develop a systematic method to assess and document:
  - Blood sugar trends since the previous SN visit. If blood sugars are assessed more than one time daily then your assessment should be documented specific to the times of day the patient tested the blood sugars
  - If the patient reports abnormal BS readings, assess and document events that may have contributed to abnormal readings such as diet, illness, or failure to take medication. Report readings outside of the established parameters to the physician
  - Document compliance with oral diabetic agents, insulin, use of sliding scale insulin, and adjunctive medication
  - Teach diabetic management based on needs identified during the initial visit. Teaching may include but is not limited to, use of glucometer, injections, specific elements of the diabetic diet, sick day management, proper foot care, treatment of hypo or hyper glycemia, disease process and complications, and when to report problems
  - Document your specific teaching and the patient's level of understanding. This is important when repeated teaching is needed

#3) PAIN ASSESSMENTS AND MANAGEMENT

Pain should be assessed and documented by nursing and therapists. Assess and document the patient's pain as part of the initial skilled nursing ealuation, therapy evaluations, and all follow-up visits. The goal for pain management should be measureable. For example, state the pain goal as "2" on a 1 – 10 scale rather than as "pain at level acceptable to patient." The documentation for all pain assessments should include –

- The rating of pain using a standardized pain scale, either verbal or non-verbal
- The location, type and quality of pain
- Document the history of pain - this may be a 24 hour recall or pain since last SN or therapy visit
- if you document “no pain at present time” still document a history to determine if the patient truly has no pain or if the patient’s pain is well controlled with the prescribed regimen
- Document specific medication or medications taken by the patient and how often the patient used each medication and the effectiveness
- Consistently assess and document if the patient is satisfied with the level of pain control
- Document coordination with the physician and between disciplines if pain goals are not met
- The SN and/or therapist should document patient and caregiver education and level of understanding regarding pain and symptom management and the medication regimen
- Document non-pharmacological methods of pain control and the effectiveness of ice, heat, TENS, massage, meditation, etc
- Obtain / document physician orders for ice, heat, TENS, ultrasound, massage or other modalities used for pain management. Orders must include the location, frequency of use, length of use and settings if applicable

#4) WOUND ASSESSMENTS AND CARE

Documentation for complete assessment of wounds is required as part of each comprehensive assessment and then according to agency policy. Usually we see wounds completely assessed including measurements at least one time a week and with any changes in treatment or wound status.

- Complete wound assessment documentation should include:
  - Location of wound – if multiple sites, use consistent and correct anatomical terminology in identifying each wound. If wounds are numbered use a consistent numbering system
  - Measurements – length x width x depth
    - Use a head to toe and side to side reference guide
    - Use a linear measurement guide
    - Measure in centimeters
    - Measure depth of wound using a cotton swab
    - Measure tunneling and undermining using the clock method
  - Appearance – color and appearance of wound bed and surrounding tissue
  - Describe tissue types in the wound bed – granulation, slough, eschar - describe in % if multiple tissue types noted
  - Drainage – color, type, and amount
  - Odor
  - Pain – note if pain present only with wound care or at other times
- Remember – Only pressure ulcers are stageable. Do not down-stage pressure ulcers as they heal
- Documentation of wound assessment at each visit should include at a minimum:
  - Location
  - Appearance
  - Odor
  - Drainage
  - Pain
- Documentation of the wound care performed by the SN should include:
  - The specific treatment done to each wound including the cleansing agent used, products applied to wound bed and surrounding area, and the type of dressing applied
  - If your agency documents "wound care per physician's order" you MUST specify the date of the order you are following
- Physician orders for wound care should include:
  - Location of wound
  - Cleansing agent
  - Medication or specific product to be applied to the wound bed or surrounding area
  - Type of dressing
  - Method of securing dressing
  - Frequency of dressing change
  - Who will be taught to do the dressing change in the absence of the SN, if applicable
- For multiple wounds with different wound care, orders should be specific for each wound
- Before the patient or caregiver independently provides wound care, the SN should document teaching including a return demonstration of the dressing change procedure. At subsequent visits, the SN should assess and document if the patient or caregiver is compliant with the dressing change as ordered by the physician